MULTIPLE SITES - 2006 RESIDENTIAL TREATMENT COST REPORT
SCHEDULE A-1

Tax ID #: ______________________

FACILITY NAME: ______________________

Multiple Sites 1 - 6

1. Name of Facility:		4. Medicaid Provider Number:
Street :		5. Name of Contact Person/Director/Administrator:
City, State, Zip Code:		6. Licensed Bed Capacity for THIS FACILITY:
2. Telephone No.:		7. Resident or Occupied Days:
3. E-Mail (if available) :		8. Level of Care

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